Quality Improvement Program and Work Plan

2013-2014

Fiscal Year July 1, 2013-June 30, 2014

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INTRODUCTION

In accordance with California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440, San Diego County Behavioral Health Services (SDCBHS) has a Quality Improvement Program and an Annual Quality Improvement Work Plan.

The goals of SDCBHS Quality Improvement Program are based on the healthcare quality improvement aims identified by the Institute of Medicine's (IOM) report: "*Crossing the Quality Chasm*." The targeted quality improvement aims for all healthcare services are to be *safe, client centered, effective, timely, efficient and equitable.* These IOM aims are interwoven throughout the Quality Improvement Program and Quality Improvement Work Plan. In addition, both are guided by San Diego County Behavioral Health's mission statement and guiding principles.

SDCBHS Guiding Principles:

- to foster continuous improvement to maximize efficiency and effectiveness of services
- to support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems, and problem gambling
- to maintain fiscal integrity
- to ensure services are:
  - outcome driven
  - culturally competent
  - recovery and client/family centered
  - innovative and creative
- to assist County employees to reach their full potential

San Diego County Behavioral Health Services

Mission Statement:

To help ensure safe, mentally healthy, addiction-free communities. In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services

Quality Improvement Program (QIP) FY 2013-14

Quality Improvement Program Purpose

The purpose of the San Diego County Behavioral Health Services (SDCBHS) Quality Improvement Program is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance abuse, and administrative services available.

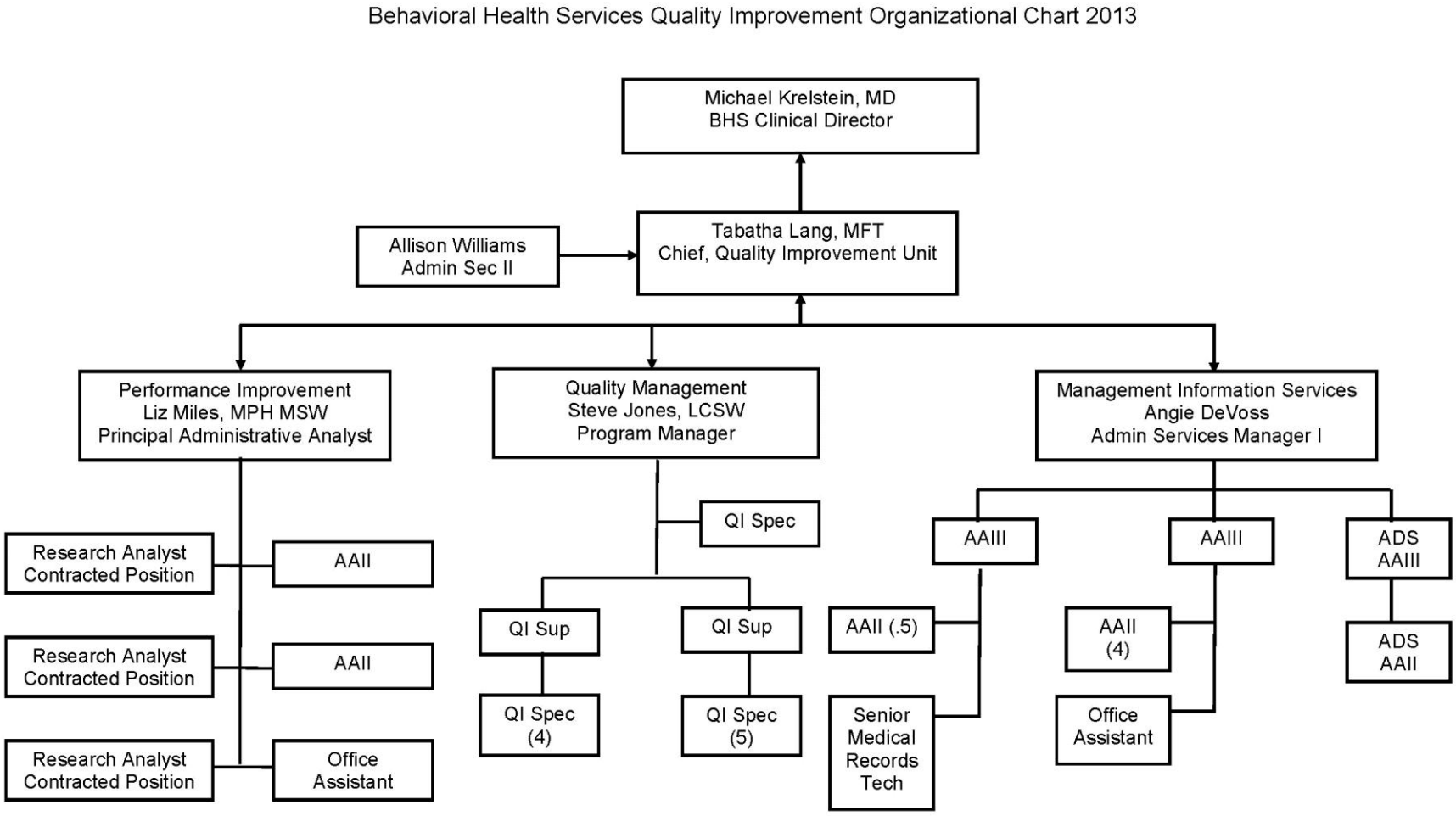
The Quality Improvement Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance abuse services provided. The Quality Improvement Program encompasses the efforts of clients, family members, clinicians, mental health advocates, substance abuse treatment programs, QI personnel, and other stakeholders.

The Quality Improvement Program and Work Plan are based on the following values:

- Development of Quality Improvement Program and Quality Improvement Work Plan objectives is completed in collaboration with clients and stakeholders.

- Client feedback is incorporated into the Quality Improvement Program and Quality Improvement Work Plan objectives.

Quality Improvement Unit Organizational Chart



QI Org Chart 8.19.13.doc

Quality Improvement Program Structure

The following are components of the structure of the Quality Improvement Program (QIP):

- Executive Quality Improvement Team (EQIT)

  The EQIT is responsible for implementing the Quality Improvement Program, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating quality improvement activities. The EQIT consists of BHS Director, BHS Clinical Director, Assistant Deputy Directors, and QI Chief. The EQIT reviews Serious Incidents and Grievances at least quarterly.

- Quality Improvement Performance Improvement Team (QI PIT)

  The QIP includes the SDCBHS QI PIT, which monitors targeted aspects of care on an on-going basis and produces reports monthly, quarterly, or annually. High-volume, high-frequency, and high-risk areas of client care are given priority. So opportunities for improvement can be identified, the QI PIT collects data which are analyzed over time and used to measure against goals and objectives. Reports in each of these areas are periodically brought to the EQIT and QRC for input.

- Quality Review Council (QRC)

  The QIP includes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for MH and the QI Work Plan (QIWP). The QRC meets at least quarterly, and the members are clients or family, as well as stakeholders, from the mental health and substance abuse community across all regions. The QRC provides advice and guidance to SDCBHS on developing the annual QIWP, including identification of additional methods for including clients in quality improvement activities; collection, review and evaluation of quality improvement activities; consideration of options for improvement based upon the report data; and recommendations for system improvement and policy changes.

  - Quality Improvement Committees (QICs)

    The QICs are subcommittees of the QRC composed of QRC members and QI staff. Subcommittee minutes and activities are monitored by the QRC. The current QRC Subcommittees are:
    - QRC Membership Committee
    - Serious Incidents (ad hoc committee)

The following diagram depicts the committees and workgroups that make up the structure of the Quality Improvement Program:

Quality Improvement Process

SDCBHS has adopted a continuous quality improvement model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key treatment, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built into the performance of the SDCBHS functions. This objective is met through a commitment to quality from the administration, QI staff, clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of SDCBHS. It is applied when examining the care and services delivered by the SDCBHS network of providers, programs, facilities, and Optum, the Administrative Service Organization.

Client and Family Involvement in Quality Improvement

Consistent with our goals of involving clients and family members in the quality improvement process, many of the QI activities are based on input from clients and family members

Clients, family members, providers and stakeholders are involved in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources including the Mental Health Board, Alcohol and Drug Advisory Board, community coalitions, planning councils, client and family focus groups, client- and family-contracted liaisons, youth and Transitional Age Youth (TAY) representatives, Program Advisory Groups, client satisfaction surveys, client advocacy programs, complaints, grievances, and input from the County Behavioral Health website.

Goals of Quality Improvement

The goals of the quality improvement process are to:

1) Identify important practices and processes where improvement is needed to achieve excellence and conformance to standards
2) Monitor these functions accurately
3) Draw meaningful conclusions from the data collected using valid and reliable methods
4) Implement useful changes to improve quality
5) Evaluate the effectiveness of changes
6) Communicate findings to the appropriate people
7) Document the outcomes

For FY 2013-14, we have noted the areas of the Quality Improvement Work Plan that are based on input from clients and family members.

Quality Review Council (QRC) Focus

QRC has identified the following as quality concerns, and, therefore, as focus topics for FY 2013-14:

- *Safety:* reducing serious incidents, reducing usage of seclusion and restraints in mental health settings

- *Client-centered services:* client and family satisfaction/dissatisfaction, provider transfer requests, customer service, client and family involvement in QI, client and family input to contract statement of work requirements, more info and improved communications to and with clients, families and communities, client grievances, "no one is listening to me" and client rights issues, monitoring of requests for Appeals and State Fair Hearings

- *Effective:* quality of care, continuity of care, developing a recovery culture, monitoring standards of care and requiring accountability, client outcomes, meaningful client employment and benefits, comprehensive screening of behavioral health issues throughout the system, trauma informed

- *Equitable:* addressing racial/ethnic/cultural and linguistic disparities, with a special focus on mental health and substance abuse services for children and youth, TAY, individuals receiving foster care currently or in the past, and veterans

- *Efficient:* systems issues – capacity, planning for population growth, referrals, access, gaps, efficiency of services, with a focus on reducing bureaucratic barriers to improving services and client outcomes

- *Timely:* wait time for assessment, wait time for admission, wait time between hospitalization and first outpatient service

Performance Improvement Projects (PIPs)

In addition to all of the other items that are part of the QIP covered under the QI Unit, at least two Performance Improvement Projects (PIPs) are conducted annually by SDCBHS. For FY 2013-14, the PIPs will be:

1) Reducing Psychiatric Readmissions Clinical Study
2) Creating a Trauma Informed System Administrative Study

Targeted Aspects of Care Monitored by QI Unit

Appropriateness of Services:

- Utilization Management
- Assessment
- Level of Care
- Treatment Plans
- Discharge Planning
- Education Outcomes
- Employment Outcomes

Access to Routine, Urgent and Emergency Services

- Call Volume for the Access and Crisis Line (ACL)
- Wait Times for Assessments
- Access to Crisis Residential Services
- Access to Inpatient Hospital Beds
- Access to Residential Treatment Services

Utilization of Services

- Average Length of Stay (ALOS) for Hospitals
- Readmission Rate
- Patterns of Utilization
- Retention Rate
- Completion Rate

Client Satisfaction

- Grievance
- Provider Transfer Requests

Cultural Competence

- Analysis of Gaps in Services
- Penetration Rate of Populations
- Provider Language Capacity
- Use of (Verbal and Non-Verbal) language Interpreters Services
- Training Provided and Participation

Client Rights

- Quarterly Client Rights Reports
- Conservatorship Trend Reports
- Patient Advocate Findings
- LPS Facility Reviews

Effectiveness of Managed Care Practices

- Provider Satisfaction
- Provider Denials and Appeals
- Credentialing Committee Actions
- Client Appeals and State Fair Hearings

Coordination with Physical Health and Other Community Services

- Integration with Physical Health Providers
- Outcomes Resulting from Improved Integration
- MOUs with Healthy San Diego

Safety of Services

- Medication Monitoring
- On-Site Review of Safety

Quality Improvement Work Plan (QIWP) FY 2013-14

Developing the Quality Improvement Work Plan

The purpose of the SDCBHS Quality Improvement Work Plan (QIWP) is to establish the framework for evaluating how the Quality Improvement Program (QIP) contributed to meaningful improvement in clinical care and administrative services. The QIWP defines the specific areas of quality of services, both clinical and administrative, that SDCBHS will evaluate for FY 2013-14.

The QIWP defines the 1) objectives, 2) goals, 3) indicators and/or measures, 4) planned interventions, and 5) data collection and planned reports. The QIWP includes plans for monitoring previously identified issues, sustaining improvement from previous years, and tracking of issues over time.

The QIWP will be monitored and revised throughout the year, as needed. The QIWP is reviewed by the QRC and approved by the EQIT. A formal evaluation will be completed annually.

Quality Improvement Work Plan Goals

The Quality Improvement Work Plan Goals define targeted measures by which Behavioral Health can objectively evaluate the quality of services, both clinical and administrative, provided to clients and families. Some of the goals are process goals while others are measurable objectives. The target areas for improvement have been identified in the following ways:

1) Client and family input about areas that need improvement
2) Systemwide issues identified through data and analysis

Annual Evaluation of QIWP

SDCBHS shall evaluate the QIWP annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The Quality Improvement Director is responsible for coordinating the QIWP Evaluation. The assessment will include a summary of completed and in-process quality improvement activities, the impact of these processes, and the identified need for any process revisions and modifications.

Target Objectives for the QIWP

The targeted objectives of the QIWP are based on the IOM aims and address QRC recommendations, to ensure high-quality clinical and administrative services are being delivered to clients and family members in San Diego County.

QIWP Target Area: Services Are Client Centered					
#	**Based on:**	**Goal:**	**Indicator/Measure:**	**Method for Data Collection:**	**Proposed QI Intervention or previous next steps:**
1	Client and family concerns EQR 3rd Year	Improve satisfaction with MH provider interactions and services by reducing complaints and grievances related to customer service by 10% since FY 2011-12	# of complaints and grievances related to customer service/staff interactions (i.e., doctor does not listen, staff are rude, etc.) # of complaints and grievances related to wait times. Trend across all available data years	Input on client satisfaction surveys related to customer service/staff interactions Information from other methods of client/family input related to customer service/staff interactions Grievances related to customer service/staff interactions Program Monthly/Quarterly Status Reports with complaints or provider transfer requests related to customer service/staff interactions	Consider implementing a new process for collecting this information from ADS programs Plan a QI focus group with Mental Health legal entities representatives to discuss how to address this Develop a client communication report from the client satisfaction information and distribute to programs QI to take suggestions and transfer data from program reports to provider meetings for feedback
2	Client and family concerns EQR New	Establish a baseline of peer and family support specialist positions within BHS.	# of Peer and Family positions available in the BHS system # of peer-run programs Trend across all available data years	Workforce Education and Training (WET) Survey Peer Support Specialist Survey	Continue to collaborate with WET, RI and FYRT Roundtable programs Continue to enhance programs that are client and family staffed, such as Bridges to Recovery and Hope Connections

QIWP Target Area: Services Are Client Centered (cont.)					
3	State Required Ongoing	Conduct Quarterly Evaluations of: o Grievances o Fair Hearings o Provider Transfer Requests	# and type of grievances # of Fair Hearings # of provider transfer requests & reasons for requests Trend across all available data years	Quarterly Grievance Report Monthly Fair Hearing Report Annual reports are presented to Quality Review Council MH tracks provider transfer requests through provider Monthly/Quarterly Status Reports and quarterly report from Optum for Fee-For-Service (FFS)	Grievances for county, contracted organizational providers are reported to program monitors. Grievances for FFS providers are reported to ASO Develop a client communication report from the client satisfaction information and distribute to programs Advocacy contractors to report out on trends of incomplete grievances

QIWP Target Area: Services Are Safe					
#	**Based on:**	**Goal:**	**Indicator/Measure:**	**Method for Data Collection:**	**Proposed or Planned QI Activity or Intervention:**
4	Systemwide issues 4th Year	Reduce the number of serious incidents by 5% since FY 2012-13.	# of serious incidents # of times programs were required to complete RCA Trend across all available data years	Programs required to report Serious Incidents to QI Monthly/Quarterly Serious Incident Report QI Report Analyze impact of expansion of SI reporting form (now includes ADS and more specific indicators)	Root Cause Analysis Process utilized by all programs if there is a suicide or major breach of confidentiality Implementation of Risk Assessment tool Train all clinical staff on new tool to use to assess for risk

QIWP Target Area: Services Are Safe (cont.)					
5	Systemwide issues New	Determine which of the recommended SDCBHS Assessment: Trauma-informed Care Interventions are appropriate for FY 2013-14		Review Trauma Informed Care domains from the National Council for Community Behavioral Healthcare (NCCBH) Collaborate with BHS NCCBH steering committee Implement BHS Trauma Informed Care workgroup Include NCCBH county representative on Community Trauma Informed Care Guide Team	Review the recommendations of the SDCBHS Assessment: Trauma-Informed Care Interventions and determine which recommendations ones to focus on Implement Trauma Informed Care PIP following the NCCBH project guidelines

QIWP Target Area: Services Are Effective					
#	**Based on:**	**Goal:**	**Indicator/Measure:**	**Method for Data Collection:**	**Proposed or Planned QI Activity or Intervention:**
6	Client and Family concerns 2nd Year	Continue integration in Primary Care/MH/ADS	% of providers that implement the Coordination of Care form # of webinars/trainings provided by the Integration Institute # of programs with Paired Provider Model % of clients with a Primary Care Provider # of ADS providers using CHOIS measure	Anasazi report on number with Primary Care SmartCare Integrated Behavioral Health Outcomes	Programs to enter primary care information into the Assessment form in Anasazi & data to be reported annually 4th Annual Integration Summit: "Working together to treat the whole person" Medical Record Reviews to include gathering information on coordination of care

QIWP Target Area: Services Are Effective (cont.)					
7	Systemwide issue	Establish a baseline for the percent of Medi-Cal and Indigent clients discharged from a psychiatric hospital (including SDCPH and CAPS) who connect to outpatient services	CO-20 (Optum report) will track services received by clients following discharge	IHOT program Review (# served by IHOT & Use of high-level services by IHOT clients) Assess success of Bridges to Recovery and Hope Connections programs Interventions developed by Readmissions Workgroup	Match reports with ADS clients to see if other services are being utilized Examine types of services used after discharge for patterns of care Discuss how to gain participation from Health Plans
8	Systemwide issue EQR 4th Year	Reduce the number of hospital readmissions within 30 days by 5%	# of hospital readmissions within 30 days Trend of hospital readmissions within 30 days	Optum readmissions reporting Data gathered through Learning Collaborative Readmissions Project	High utilizers are tracked and reports are used by ACT and FSP programs for follow-up Continue meetings between Hospital Partners and OP programs to identify methods to reduce readmissions Develop new report that analyzes how many are connected to OP services within seven days Readmissions PIP

QIWP Target Area: Services Are Efficient and Accessible					
#	**Based on:**	**Goal:**	**Indicator/Measure:**	**Method for Data Collection:**	**Proposed or Planned QI Activity or Intervention:**
9	State Required Ongoing	Provide specialty mental health services to 2% of county population	# Specialty MH clients in ratio to # of SD County residents % of county population served	Quarterly reports and Databook Annual System of Care reports	Minimize reductions in unduplicated clients served in OP/CM due to budget reductions Plan for increases in Medi-Cal population (expected to increase by 12% by 2020) and Expanded Medi-Cal (2014)

QIWP Target Area: Services Are Efficient and Accessible (cont.)					
10	State Required Ongoing	Ensure that 95% Client and Provider Appeals of Managed Care decisions are addressed within timelines	# of denials # of level 1 and 2 appeals # upheld and overturned # of expedited appeals requests Timeliness of all denials and appeals	Optum Denial and Appeal Report Track denials by provider, facility and Optum staff to analyze trends Continue to work with Optum staff to improve documentation on TARs for authorizations and denials	Missed timelines may result in having to complete a corrective action plan

QIWP Target Area: Services Are Equitable					
#	**Based on:**	**Goal:**	**Indicator/Measure:**	**Method for Data Collection:**	**Proposed or Planned QI Activity or Intervention:**
11	State Required Ongoing	75% of clients and families indicate that they had access to written info in their primary language and/or received services in the language they prefer	# of surveys completed in threshold languages MHSIP and YSS responses to items focused on cultural competency	Annual client satisfaction survey, including threshold languages from MHSIP and YSS	Provide all beneficiary packet materials in each threshold language Regularly evaluate and update translated documents
12	Systemwide issue 2nd Year	Standardize cultural competency (CC) requirements across ADS & MHS providers	Maintenance of provider CC plans # of CC opportunities provided Penetration rates for underrepresented groups of interest BHETA Cultural Competence Academy Outcomes indicators Changes in LGBTQ tracking compliance	Annual administration & review of the CC-PAS and Bi-Annual administration & review of the CBMCS Track utilization of services by underrepresented groups (Foster Youth, African Americans, Girls)	Develop new Cultural Competence Academy QI to add new elements of cultural competency to the medical record review tool Update Disparity Report to identify services gaps every three years (next report for FY 2013-14 data) Develop Disparity Snapshot that provides a brief look at prior fiscal year disparity data

QIWP Target Area: Services Are Timely					
#	**Based on:**	**Goal:**	**Indicator/Measure:**	**Method for Data Collection:**	**Proposed or Planned QI Activity or Intervention:**
13	State Required Ongoing	Establish routine monitoring (quarterly)of: o Timeliness of routine MH/ADS services o Timeliness of services for urgent conditions o Access to after-hours care o Responsiveness of the ACL	Wait times for MH, ADS and Psychiatric Assessments Utilization of ESU, EPU, Crisis Res, ACL ACL statistics, including items of calls # of PERT contacts	An eight-day wait times standard has been developed for A/OA and five days for children Access to after-hours care is provided by EPU, ESU, PERT, Crisis Residential ACL standards as contracted are tracked quarterly. Optum is subject to a contract payment withholding if they are unable to meet the standard	Wait time reports on routine MH services submitted by programs Admission discharge and census for after-hours programs PERT report on access in Emergency rooms ACL Contract Standard reports Hospital discharge report Investigate developing a report that analyzes wait times from Assessment to initial treatment service